

South Carolina Department of Social Services  
ABC Child Care Voucher System  
**SELF-ARRANGED CHILD CARE PROVIDER ENROLLMENT FORM**

Social Security No.: \_\_\_\_\_ Relative of Child: ☐ Yes ☐ No \_\_\_\_\_  
Relationship to Child

Provider Name: \_\_\_\_\_

Provider County: \_\_\_\_\_ Provider Telephone: \_\_\_\_\_

Provider Address: \_\_\_\_\_  
(Street Number, Post Office Box or Route Number)

Provider City/State: \_\_\_\_\_ Provider Zip Code: \_\_\_\_\_

Provider Payment Address (if different than above)

Address: \_\_\_\_\_  
(Street Number, Post Office Box or Route Number)

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Payment Telephone: \_\_\_\_\_

☐ Registration ☐ License ☐ Not Applicable

**Provider Category:** (Mark one "X" in each column)

Private-for-Profit	X	Minority Owned	Sole Proprietor	X	State Employee	
		Non-Minority Owned			Non-State Employee	
					Legislator	

Days of Operation: (Circle all that apply) M TU W TH FRI SAT SUN

Hours of Operation: \_\_\_\_\_ a.m. to \_\_\_\_\_ p.m. How Many Children in Care: \_\_\_\_\_

**Provider Type:** (Check one)

In-Home Relative (IHR)		Non-Regulated Relative (NRR)	
In-Home Non-Relative (IHN)		Non-Regulated Non-Relative (NRN)	

**Care Types:** (Check all that apply)

	Full-Time	Half-Time	Less than Half-Time Care
0-2 Years			
3-5 Years			
6-12 Years			

**For Agency Use Only:**

Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_

## INSTRUCTIONS FOR DSS FORM 3774

- Social Security No.:** Enter your Social Security number as it is on your Social Security card.
- Relative of Child:** Check one. Yes, if you are related by blood or law to the child, write in your relationship (Grandmother, sister, aunt, cousin etc.). No, if you are not related by blood or law.
- Provider Name:** Write in your full legal name.
- Provider County:** Write in the name of the county where you live.
- Telephone Number:** Write in your home telephone number or the telephone number where you can be reached while the children are in your care.
- Provider Address:** Write your complete address with street number and name or post office box. If you live on a rural route, please put the name of the road or highway.
- Provider City/State:** Write your city or town name and state.
- Provider Zip Code:** Write your 5- or 9-digit zip code.
- Provider Payment Address:** Write in the address you want us to send your checks if it is different from the address above.
- License/Registration:** Check the correct box if you have a license or registration from the Department of Social Services (DSS) to provide regulated child care.
- Not Applicable:** Check this box if you are **NOT** licensed or registered by DSS.
- Provider Category:** Mark the correct box.
- Mark Non-Minority if you are a white male, otherwise, mark minority owned.
- Mark state employee if you are an employee of the State of South Carolina, non-state if you are **NOT** an employee of the State of South Carolina or legislator if you are an elected official of the South Carolina State General Assembly.
- Days of Operation:** Write in the days you will care for the child(ren).
- Hours of Operation:** Write in the time the child(ren) arrives and the time the child(ren) leaves each day.
- How Many Children in Care:** Write in the number of children you care for.
- Provider Type:** Check in-home relative if you provide care for a child that is related to you, in their home.
- Check in-home non-relative if you provide care for a child that is not related to you, in your home.
- Check non-regulated relative if you provide care for a child that is related to you, in your home.
- Check non-regulated non-relative if you provide care for a child that is not related to you, in your home.
- Care Type:** Mark the correct box for the age of the child you provide care for and if you provide care for the child full time or half time.